

Wade-Taxter, Megan (ISDH)

From: Reynolds, Anne
Sent: Thursday, August 09, 2018 3:34 PM
To: Humbarger, Cathie
Subject: RE: records request
Attachments: PR#4122 TP Reports July 2018.pdf

Hello Cathie,

Please see the attached PDF document with the terminated pregnancy reports for July 2018.

Thank you,

ANNE REYNOLDS, MPH
Vital Records Epidemiologist

Vital Records
Indiana State Department of Health
317.234.0280 office
317.233.1289 fax
AReynolds1@isdh.IN.gov
www.StateHealth.in.gov



Confidentiality Statement:

This message and any attachments may be confidential. If you are not the intended recipient, please 1) notify me immediately; 2) do not forward the message or attachment; 3) do not print the message or attachment; and 4) erase the message and attachment from your system.

From: Cathie Humbarger <cathie.humbarger@ichooselife.org>
Sent: Thursday, August 9, 2018 1:55:33 PM
To: Sautbine, Hilari A
Subject: records request

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****



August 9, 2018

Hilari Sautbine
Vital Records
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Ms. Sautbine,

Thank you so much for your quick response to our past requests for public records.

I am requesting copies of the original termination of pregnancy reports as submitted by the abortionists for terminations in Indiana from July 1, 2018 through July 31, 2018. It is my understanding that SEA 404 amended the Indiana Code to require that all abortions performed in Indiana be reported within 30 days (IC 16-34-2-5(b)). I understand that reports will be provided on discs or electronically. Please send the discs to the address below or e-mail to cathie.humbarger@ichooselife.org.

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:

Cathie Humbarger, VP
Indiana Right to Life
2126 Inwood Drive
Fort Wayne, IN 46815

Sincerely,

A handwritten signature in cursive script that reads "Cathie Humbarger".

Vice President of Policy Enforcement
Indiana Right to Life

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address SIDNEY AND LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion fetal anencephaly		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (Specify) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/20/2018		Physician estimate of gestation (in weeks) 18		Post fertilization age of the fetus (in weeks) 16	
How were the gestational age and post fertilization age determined? LMP					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. HUA MENG					
Address of physician performing termination (number and street, city, state, and zip code) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/27/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Master's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Fetal cystic hygroma, aneuploidy		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/13/2018		Physician estimate of gestation (<i>in weeks</i>) 14		Post fertilization age of the fetus (<i>in weeks</i>) 12	
How were the gestational age and post fertilization age determined? LMP					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. HUA MENG					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/27/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 04/28/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/06/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 04/23/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/14/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/11/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/30/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 4	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 1998 2. 2000 3. 2001 4. 2007 5. 2016 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/18/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2015 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/06/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/13/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2012 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/09/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/05/2018	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/14/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/17/2018	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/08/2018	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 04/24/2018	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/26/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2006 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/17/2018	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/09/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/01/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): 07/11/2018

DATE RECEIVED BY ISDH (month, day, year): 07/11/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/28/2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/12/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/14/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/26/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/12/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Unknown		
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/03/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/23/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 4		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/29/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/10/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/12/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/10/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2007 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/21/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Master's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 12/18/2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/08/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/2011 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2011 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/31/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 5		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2015 2. 2017 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/18/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/12/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A		
Date last normal menses began 05/08/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/12/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/13/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/02/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 01/2018 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education 9th-12th, No Diploma		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/09/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Associate Degree			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown			
Live Births:		Number now living 3		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/15/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 3		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/28/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 12/12/2017 2. 10/05/2015 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/13/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/29/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/12/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 05/2018 3. 2017 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education 9th-12th, No Diploma		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 09/24/2013 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Unknown		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/30/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/13/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/03/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/11/2016 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/25/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/15/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/29/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2018 2. 2016 3. 2015 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/05/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/03/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2008 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/24/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/11/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/29/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 04/21/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/21/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/02/2018		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2007 3. 2009 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/30/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/16/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/16/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/13/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2011 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 2018 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/11/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/04/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 2013 3. 2017 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) na			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2015 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/03/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0		Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. MANDY GITTLER			
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410			

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/19/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began 05/06/2018		Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? ULTRASOUND			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. MANDY GITTLER			
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410			

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0		Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began 05/02/2018		Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
How were the gestational age and post fertilization age determined? ULTRASOUND			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. MANDY GITTLER			
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410			

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/26/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/08/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/04/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/30/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 5	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/11/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/16/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 2015 3. 2013 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/30/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/20/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2013 2. 2015 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

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Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/02/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/28/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018	Education 9th-12th, No Diploma		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Seizure disorder.	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE			
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1		Number now deceased 1			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 06/26/2018	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KRISTY L NEWTON		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/11/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/02/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KRISTY L NEWTON		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/23/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/29/2018	Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KRISTY L NEWTON		
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268		

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 06/04/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/27/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/18/2017 2. 03/11/2017 3. 05/06/2015 4. 12/16/2014 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/24/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KRISTY L NEWTON		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/10/2018	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KRISTY L NEWTON		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/20/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 06/30/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KRISTY L NEWTON					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN RD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/20/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/19/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KATHLEEN GLOVER					
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/27/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/12/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/03/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/12/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/10/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/17/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 04/28/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/06/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/18/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 02/2018 2. 02/2017 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/14/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 4		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/30/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/21/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/09/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/2017 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/06/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/23/2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/20/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/21/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/05/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/06/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/23/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/19/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/29/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/05/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 6		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018	Education Master's Degree				
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown				
Live Births:	Number now living 2		Number now deceased 0				
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0				
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/18/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/06/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2009 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/20/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/18/2013 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/01/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/02/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		history of uterine surgery		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/25/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion asthma		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/23/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/29/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE			
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 06/06/2013 2. 11/10/2016 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/11/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/22/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/20/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/30/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON		County of pregnancy termination MONROE	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/05/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		history of uterine surgery	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input checked="" type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/26/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/22/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/25/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/28/2018	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/20/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/04/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7			
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/19/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 6		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 2015 3. 2013 4. 2010 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/10/2018	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 2014 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/28/2018	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/23/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/26/2018	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2018 2. 1998 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 04/30/2018	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2001 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 2015 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/10/2018	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/14/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 5		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 2000 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/15/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/10/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Associate Degree			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/17/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6			
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2005 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <hr/> Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) <hr/> Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/05/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/13/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED				
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown				
Live Births:	Number now living 1		Number now deceased 0				
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1				
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>				
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:						
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:						
<div>Type of Termination Procedures</div> <table><tr><td><div>Procedure that Terminated Pregnancy</div><div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div><div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div><div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div><div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></td><td><div>Additional Procedure that Terminated Pregnancy</div><div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div><div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div><div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div><div>For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></td></tr></table>						<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. 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Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>						
Date last normal menses began 05/14/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 12/18/2015 2. 06/24/2016 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 05/25/2012 2. 02/02/2013 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 05/21/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/16/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/23/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/03/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 05/04/2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/15/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/16/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/13/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/23/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education 8th Grade or Less		
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 4		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/25/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/25/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 03/09/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/29/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/14/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 3		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Bachelor's Degree			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 06/03/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/04/2016 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 2		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 07/2017 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 08/07/2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 2		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 07/20/2016 2. 03/16/2017 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/23/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education 9th-12th, No Diploma		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 07/25/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): 07/25/2018

DATE RECEIVED BY ISDH (month, day, year): 07/25/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/26/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KATHLEEN GLOVER					
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222					

**Date Reported to DCS, if Patient under 16 (month, day, year): 07/27/2018

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 13	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education 8th Grade or Less		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

Date Reported to DCS, if Patient under 16 (*month, day, year*): **07/27/2018

DATE RECEIVED BY ISDH (*month, day, year*): **07/27/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/04/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/28/2018		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 06/15/2018	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 2015 3. 2012 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began 05/29/2018	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 2016 3. 2015 4. 2014 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education 9th-12th, No Diploma			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7			
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. JEFFREY D. GLAZER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. JEFFREY D. GLAZER			
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219			

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 06/10/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/06/2018	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 2009 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 06/05/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input checked="" type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/09/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2002 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2006 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/26/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

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Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 06/16/2018	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. JEFFREY D. GLAZER		
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219		

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2017 2. 2014 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/06/2018	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. JEFFREY D. GLAZER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/30/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/31/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/24/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 46	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 4	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2004 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/16/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. MANDY GITTLER					
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/10/2018		Physician estimate of gestation (in weeks) 5		Post fertilization age of the fetus (in weeks) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2012 2. 12/2017 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/11/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/18/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (<i>in weeks</i>) 10		Post fertilization age of the fetus (<i>in weeks</i>) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2013 2. 2012 3. UNKNOWN 4. UNKNOWN 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/31/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/05/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 19	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/29/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/12/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2016 3. 2017 4. 2017 5. UNKNOWN 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2014 2. 2017 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/31/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. 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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/31/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5			
How were the gestational age and post fertilization age determined? ULTRASOUND							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CAROL DELLINGER							
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225							

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 42	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/2012 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 2	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 13		Post fertilization age of the fetus (<i>in weeks</i>) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 2		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/21/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 10/21/2017		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/31/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/27/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/04/2018		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CAROL DELLINGER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **07/31/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/11/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1		Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? ULTRASOUND			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. SARAH JULIA TURNER			
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268			

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2		Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? ULTRASOUND			
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	
Full name of physician performing termination DR. SARAH JULIA TURNER			
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268			

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 03/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/30/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/11/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE		County of pregnancy termination LAKE	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 2		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 01/10/2018 2. 07/28/2015 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/23/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF INDIANA (LAFAYETTE) - 964 MEZZANINE DRIVE, LAFAYETTE, IN, 47905		City or town, of pregnancy termination LAFAYETTE		County of pregnancy termination TIPPECANOE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 3		Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/08/2013 2. 08/29/2017 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/08/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 45	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/31/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/03/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF INDIANA (LAFAYETTE) - 964 MEZZANINE DRIVE, LAFAYETTE, IN, 47905		City or town, of pregnancy termination LAFAYETTE		County of pregnancy termination TIPPECANOE	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018	Education High School Diploma or GED		
Race <input checked="" type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 06/27/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF INDIANA (LAFAYETTE) - 964 MEZZANINE DRIVE, LAFAYETTE, IN, 47905		City or town, of pregnancy termination LAFAYETTE		County of pregnancy termination TIPPECANOE	
Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PLANNED PARENTHOOD OF INDIANA (LAFAYETTE) - 964 MEZZANINE DRIVE, LAFAYETTE, IN, 47905		City or town, of pregnancy termination LAFAYETTE		County of pregnancy termination TIPPECANOE	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/18/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 10/06/2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. SARAH JULIA TURNER					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 2	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education 8th Grade or Less	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Master's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/13/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 07/25/2018		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/12/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/21/2018		Physician estimate of gestation (<i>in weeks</i>) 5		Post fertilization age of the fetus (<i>in weeks</i>) 3	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/03/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 04/22/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/10/2018		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 03/21/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/05/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 42	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 2		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/26/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/24/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/08/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/03/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/24/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/25/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/03/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/27/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/08/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 04/21/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/21/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/15/2018		Physician estimate of gestation (<i>in weeks</i>) 9		Post fertilization age of the fetus (<i>in weeks</i>) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/03/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/05/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/28/2018		Physician estimate of gestation (in weeks) 13		Post fertilization age of the fetus (in weeks) 11	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/12/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/24/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 05/05/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/27/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/12/2018		Physician estimate of gestation (<i>in weeks</i>) 6		Post fertilization age of the fetus (<i>in weeks</i>) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/14/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 07/09/2016 2. 12/17/2015 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/02/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) n/a			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/05/2018		Physician estimate of gestation (in weeks) 12		Post fertilization age of the fetus (in weeks) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Associate Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/08/2018		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/24/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/04/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/25/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion n/a		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/31/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/29/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 01/05/2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/16/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/26/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began UNKNOWN		Physician estimate of gestation (<i>in weeks</i>) 8		Post fertilization age of the fetus (<i>in weeks</i>) 6	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 2		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/06/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/03/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 5		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/01/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 01/20/2018 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/13/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 06/07/2018		Physician estimate of gestation (<i>in weeks</i>) 7		Post fertilization age of the fetus (<i>in weeks</i>) 5	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 03/01/2018		Physician estimate of gestation (<i>in weeks</i>) 11		Post fertilization age of the fetus (<i>in weeks</i>) 9	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/10/2018		Physician estimate of gestation (<i>in weeks</i>) 12		Post fertilization age of the fetus (<i>in weeks</i>) 10	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): **08/01/2018**

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/28/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion N/A	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3) N/A			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? ULTRASOUND					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination DR. CASANDRA CASHMAN					
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/01/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Master's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/20/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/07/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC & CHORIONIC VILLI				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/17/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2014 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/18/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/19/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2016 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 04/11/2018	Physician estimate of gestation (in weeks) 12	Post fertilization age of the fetus (in weeks) 10
How were the gestational age and post fertilization age determined? SONOGRAM		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination RESAD PASIC		
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205		

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2017 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/20/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC & CHORIONIC VILLI				
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/06/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/24/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/21/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC & CHORIONIC VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC SAC & VILLI				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 04/19/2018	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
How were the gestational age and post fertilization age determined? SONOGRAM		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination RESAD PASIC		
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205		

**Date Reported to DCS, if Patient under 16 (month, day, year):

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TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018	Education Some College, No Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 12/30/2017 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC SAC & VILLI				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/19/2018	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked	

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205

**Date Reported to DCS, if Patient under 16 (month, day, year):

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Unknown	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC & VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/22/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

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DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC & VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/16/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 06/22/2017 3. 07/16/2016 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC & VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/28/2018		Physician estimate of gestation (in weeks) 10		Post fertilization age of the fetus (in weeks) 8	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC & VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/07/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/07/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC & VILLI			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 04/25/2018		Physician estimate of gestation (in weeks) 8		Post fertilization age of the fetus (in weeks) 6	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/17/2018		Physician estimate of gestation (in weeks) 6		Post fertilization age of the fetus (in weeks) 4	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div> <div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>					
Date last normal menses began 04/24/2018		Physician estimate of gestation (in weeks) 7		Post fertilization age of the fetus (in weeks) 5	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION			
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education High School Diploma or GED			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown			
Live Births:		Number now living 1		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					
<div>Type of Termination Procedures</div> <table><tr><td>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td><td>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</td></tr></table>						Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. 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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)						
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7			
How were the gestational age and post fertilization age determined? SONOGRAM							
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked					
Full name of physician performing termination RESAD PASIC							
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205							

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/03/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/07/2018		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
<div>Type of Termination Procedures</div> <div><div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div><div><div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div></div></div>					
Date last normal menses began 05/05/2018		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination RESAD PASIC					
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205					

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/02/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/11/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 2007 2. 2017 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC, CHORIONIC VILLI & FETAL PARTS			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		
Date last normal menses began 05/01/2018		Physician estimate of gestation (in weeks) 11		Post fertilization age of the fetus (in weeks) 9	
How were the gestational age and post fertilization age determined? SONOGRAM					
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the patient seeking an abortion as a result of being any of the following?		<input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked			
Full name of physician performing termination KATHLEEN GLOVER					
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222					

**Date Reported to DCS, if Patient under 16 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 08/06/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC AND VILLI			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div>For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)</div>

Date last normal menses began 05/05/2018	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
How were the gestational age and post fertilization age determined? SONOGRAM		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KATHLEEN GLOVER		
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222		

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/07/2018

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 07/12/2018		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 5	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion <div>Complication(s) of Pregnancy Termination</div> <div><input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)</div> <div>Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC SAC/ VILLI & FETAL PARTS			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began 04/20/2018	Physician estimate of gestation (in weeks) 12	Post fertilization age of the fetus (in weeks) 10
How were the gestational age and post fertilization age determined? SONOGRAM		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination KATHLEEN GLOVER		
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222		

**Date Reported to DCS, if Patient under 16 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 08/07/2018